LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES

January 15, 2015

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Grissel Granados, MSW, *Co-Chair*	Dahlia Ferlito, MPH *(pending)*	None	Dawn McClendon
Fariba Younai, DDS, *Co-Chair*	Suzette Flynn		Jane Nachazel
Raquel Cataldo	Kimler Gutierrez *(pending)*		
Kevin Donnelly	Mitchell Kushner, MD, MPH		
David Giugni	Patsy Lawson/Miguel Palacios		**DHSP STAFF**
Terry Goddard, MA	Angèlica Palmeros, MSW		None
Michael Johnson, Esq.			
Ricky Rosales			
Carlos Vega-Matos, MPA			

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Standards and Best Practices (SBP) Committee Agenda, *1/15/2015*
2) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *2/6/2014*
3) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *3/6/2014*
4) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *4/17/2014*
5) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *5/22/2014*
6) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *8/21/2014*
7) **Minutes**: Standards and Best Practices (SBP) Committee Meeting Minutes, *10/16/2014*
8) **Policy**: Commission on HIV, Policy on Minutes, Draft, *January 2015*
9) **Table**: FY 2014 Service Categories, *2014*
10) **Table**: HIV Prevention Interventions, *2014*
11) **Table**: Standards and Best Practices (SBP) Committee, *2014*

1. **CALL TO ORDER:** Dr. Younai called the meeting to order at 9:20 am.

2. **APPROVAL OF AGENDA:**
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES:**
   Motion 2: Approve minutes from the 2/6/2014, 3/6/2014, 4/17/2014, 5/22/2014, 8/21/2014 and 10/16/2014 Standards and Best Practices (SBP) Committee meetings, as presented **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT, *(Non-Agendized or Follow-Up)*:** There were no comments.

5. **COMMITTEE COMMENT, *(Non-Agendized or Follow-Up)*:** There were no comments.

6. **CO-CHAIRS' REPORT:** ➲ Change SBP Committee meeting time to 10:00 am to 12:00 noon going forward. Work groups will be scheduled to precede the Committee meeting from 8:00 to 10:00 am.

7. STANDARDS OF CARE (SOC) WORK SCHEDULE:

- Mr. Johnson recommended SBP develop a few best practice core values just as Planning, Priorities and Allocations (PP&A) develops its Paradigms and Operating Values for the Priority- and Allocation-Setting (P-and-A) process.
- Core values could help address questions such as that raised by Supervisorial District 4 involving the relative value of patient/client provider choice in an area versus ensuring quality services for patients/clients as a whole including attention to patient density and provider viability. There are now 40 Ryan White (RW) providers, but fewer patients are accessing Ambulatory Outpatient Medical (AOM) due to ACA implementation so RW provider numbers may decline in future.
- Supervisorial District 4 requested input on a proposed new City of Long Beach RW provider site, specifically whether quality services were now available and the relative weight of patient choice. County Counsel will address the legal contract issue and St. Mary's CARE Program has offered a short-term subcontract solution, but patient choice remains unaddressed.
- Mr. Vega-Matos reported quality services are available including four RW clinics within City of Long Beach boundaries, none with wait lists, and other services are nearby, e.g., Harbor UCLA Medical Center. DHSP has standards for density and distance to RW-contracted sites but, as elsewhere, some patients choose to use sites outside the City.
- Any clinic can choose to serve PLWH, but services can only be funded by RW if the clinic has a RW contract. Due to ACA and Medicaid Expansion, most RW medical care patients now are either undocumented or newly diagnosed PLWH who are in the process of transitioning to Medi-Cal. Invoices are backed out for the latter once Medi-Cal coverage starts.
- Ms. Cataldo noted her clinic had anticipated serving 50 to 70 medical patients, but was now down to five or six due to migration. She was reviewing options to shift funds to meet other needs.
- Mr. Johnson said how patient choice impacts health outcomes remains unsettled. A literature search could help develop core values on how to weight patient choice in a finite system. The Departments of Health Services (DHS) and Public Health (DPH) release RFPs and contract services based on the different criterion of patient numbers within a SPA. The DHS, DPH and Department of Mental Health (DMH) merger will also impact HIV+/HIV- standards in an integrated model.
- He added surveillance estimates 5,500 PLWH in the City of Long Beach. Most are known to receive care through RW or other resources with only some 500 not having an identified source so data does not reflect a notable access issue. In any case, that and economic issues are the purview of PP&A while patient choice best practices is an SBP issue.
- Dr. Younai said a literature search could review community Viral Load countrywide to compare states with a robust RW system versus those that rely on the private sector and other systems such as Kaiser. It is also established in clinical practice that management of co-morbidities becomes more difficult the further a patient is from his/her medical home.
- Mr. Giugni felt the overall patient choice subject may be useful, but the City of Long Beach question was a poor example. He believed most people who spoke in favor of an additional clinic at the Commission were volunteers, not RW patients.
- Mr. Vega-Matos added patient choice should be framed as rights and responsibilities. All patients, even those with private insurance, have limits. Some patients will rotate through all providers without satisfaction because they want detailed services immediately but, on examination, other issues are involved. An effort to tailor services to patient requests in SPA 1 did not improve engagement. All RW AOM patients can also use transportation services to access desired RW providers.
- Mr. Goddard asked if a RW health plan or "Medi-Gap" could help. Mr. Johnson replied states manage health plans so HRSA would need to revise its funding mechanisms and has shown no interest in doing so. The County could develop its own framework much like My Health LA, but Mr. Vega-Matos noted health plans still use networks, contracts and standards.

➲ Initiate a Patient Choice Work Group to do a literature search and develop a recommendation on a best practice standard for patient/client choice. Members are: Ms. Cataldo, Mr. Donnelly, Mr. Goddard, Mr. Johnson, Ricky Rosales, Mr. Vega-Matos and Dr. Younai. Messrs. Goddard and Vega-Matos will provide research on both PLWH and HIV- people for review. Dawn McClendon will schedule the Work Group meeting.

A. SOC Work Activities:

- Ms. Granados reported the Service Definition Work Group first addressed care/treatment and prevention definitions separately and then attempted to integrate them, but did not compile a final list.
- Mr. Vega-Matos said HRSA has service definitions, but the Commission has historically split out and recombined aspects. Funding, nevertheless, must be reported to HRSA per its definitions as is the case for CDC-defined services. It would facilitate DHSP's HRSA and CDC reports if services were addressed as clusters, e.g., diagnosis, Linkage to Care (LTC), engagement, Retention in Care (RIC) and virally suppressed. Services could then be applied in SOCs as needed.
- Mr. Johnson suggested framing comprehensive categories with areas broken out as needed for funder requirements. That could help address a continuum of prevention, care and co-morbidities, e.g., substance abuse and mental health. He was concerned the County's new merged DHS/DPH/DMH lens will define HIV solely as a specialty within the larger system. He sought to ensure prevention, mental health and support services as well as specialty were included.

- Dr. Younai stressed it was also important to consider standards development and its link to the Continuum of HIV Services (CHS). SBP has been planning to merge the 36 standards into 18. Service definitions need to link to standards.
- Mr. Johnson said the CHS will eventually be superseded by the movement toward integrated planning, e.g., with ACA. HRSA and the CDC pushed the Commission to integrate. Though they have not yet addressed their own integration, he urged integrating our own work and then backing into funder requirements.
- Mr. Vega-Matos suggested defining services and then fitting them into structures as needed rather than defining services by a changing structure. RW is more flexible than health plans and includes services other plans do not even though DHSP does not currently fund all potential services or every potential aspect of some funded services.
- Mr. Goddard suggested a focus on services that the current funding stream can support to maximize effective use of personnel. Significant modeling was done on housing, including focus groups, but HOPWA used very little of the work.
- Mr. Giugni stressed the importance of including HIV and STD prevention. Dr. Younai said there was discussion about developing a separate prevention standard, but the decision was to incorporate prevention into all standards.
- Mr. Goddard recommended a 30,000 foot view to address the CHS, a ground level view of standards and a 10,000 foot view to translate between the two and facilitate DHSP's work with HRSA and the CDC
- Mr. Vega-Matos said one key lens for the model might be how to link high risk HIV- people to services. The CDC has essentially eliminated Health Education/Risk Reduction in favor of HIV and STD testing. Partner services for PLWH is the only other major prevention service, but does not directly address HIV- people or their social determinants of health.
- Ms. Granados called attention to discussion of developing a PEP/PrEP standard. Mr. Vega-Matos noted PEP has been implemented, but AOM cannot fund PrEP because it serves HIV- people. The CDC can fund PrEP administrative costs and those who are insured can access it through their health plans.
- Ms. Nachazel noted PP&A needs service definitions for the first P-and-A step, prioritization regardless of funding or other resources. Allocations, the second P-and-A step, considers funding factors. A service might not be funded or have funds increased if: it is not fundable; is funded by another source; additional funds cannot be used, e.g., due to lack of staff or providers; or available funds are insufficient to make a significant difference, e.g., to support provider viability.
- Ms. McClendon will add two columns to the list of HRSA services: "currently funded by" and "fundable." She will forward the revised list to Mr. Vega-Matos who will combine it with the list of prevention services. He will provide the combined list to the Service Definition Work Group for review and report back.
- SOC-related reports to SBP: Dr. Younai will review SOC status. Mr. Vega-Matos will review LTC RFP status and status of biomedical interventions work including that of the PrEP Advisory Committee and pertinent information and/or literature. Mr. Rosales will follow-up on contract availability for the SOC focus group facilitator and writer.
- An SOC Work Group will be initiated once all reports are back to SBP and a work strategy determined.

8. **NEXT STEPS:**
   A. **Task/Assignment Recap**: There was no additional discussion.
   B. **Agenda Development for Next Meeting(s)**: There was no additional discussion.

9. **ANNOUNCEMENTS:** There were no announcements.

10. **ADJOURNMENT:** The meeting adjourned at 11:05 am.